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ABSTRACT

This document examines the sociological, psychological, and biological aspects of child abuse. It provides definitions of child abuse and historical perspectives of child abuse, the juvenile court system, and child sexual abuse. The psychology of the victim and of the offender is discussed, bibliotherapy is presented as one way of helping children who are victims of abuse to acquire coping behaviors, and multiple personality is described as one response to abuse. The section on biological aspects of child abuse looks at the theory of evolution, cultural evolution, and acts of commission and omission. It discusses methods of collecting medical evidence of abuse and explains the use of the colposcope and dye in obtaining evidence. Child advocacy is explained and the role of a child advocate is described. The purpose of a child advocacy center is discussed, programs that might be initiated at such a center are suggested, and the effects a center might have on the community are considered. Guidelines for establishing a child advocacy center are given, with suggestions for the board of directors, the interdisciplinary team, the staff, and the facility itself. Cost of operations is discussed and data collection for comprehensive evaluation is explained. (NB)

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CHILD ADVOCACY:
TODAY'S ANSWER FOR CHILD ABUSE PREVENTION

A Sociological, Psychological, and Biological Approach

A University of South Alabama Senior Project By:

Penny A. McNees

March 1987

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CHILD ADVOCACY WHAT IS IT?

GUIDELINES FOR ESTABLISHING A CHILD ADVOCACY CENTER

Penny A. McNees

Introduction

She was a pretty girl with big brown eyes, vacant and robbed of any sparkle. Her stepfather's forty-year-old brother had abducted her from two states over, driven her to a local hotel, raped her repeatedly over a three day period, then abandoned her. And she was only thirteen years old. As a rape crises volunteer counselor, the first (and last) time I saw her was in the emergency room. Fear could be seen on her face and her shoulders sagged with resignation. In the four months since I had become a volunteer doing crises intervention work, she was my tenth victim under the age of fourteen--and I had gone on call for only one twenty-four hour shift per month.

All counselors carry a box of coloring crayons and a small pad of paper in their manuals to occupy their young victims (and to help establish the caring relationship) while waiting for the doctor in the hospital examination room. That first four months, I couldn't keep enough crayons in my manual, and started carrying three boxes at a time.

I had always known that child abuse was prevalent in our modern society, but it wasn't until I looked into those big brown eyes that I began a personal quest for some answers. I have since learned that in 1984 there were 951 reports of child abuse made to the Department of Human Resources of Mobile County, and in 1985 there were 1,448 reports made, including 350 reports of sexual abuse.

We are about to embark on a journey--a journey that will hopefully bring us to a better understanding of child abuse. We will try to strip away the emotional and study the rational. We will try and gain insight into the problem by studying child abuse from the perspectives of sociology, psychology, and biology, looking at the latest theories and models on the dynamics of child abuse as found in the literature of the three disciplines. We will

then study the concept of child advocacy as a means of preventing child abuse, and finish with written guidelines for establishing a child advocacy center.

Socrates believed that true wisdom was knowing the extent of one's ignorance. His life stood for the union of rational inquiry and ethical action in all areas of life. It is my hope that anyone who reads this treatise will come away with a knowledge on the subject of child abuse that they didn't have before, and will go and apply that knowledge anyway they can and in the best interests of our children.

Penny A. McNees

Sociological Aspects of Child Abuse

What's All The Fuss About?

Why should we be so concerned about child abuse? The obvious emotional response is if we are sensitive caring human beings, then we cannot tolerate the thought of a child being hurt in any way. We should, therefore, do everything possible to protect the child and punish the perpetrator. Unfortunately, this "Band Aid" approach (as Happy Craven Fernandez called it in his Child Advocacy Handbook) does not address the broad range of problems associated with child abuse in our society today.

As Lucy Berliner, M.S.W. and a pioneer in the field of child abuse, wrote, "For many years, we have been working with children who have family problems, with children who have drug and alcohol problems, with children who have school failure, and with children who are suicidal. We never suspected that we might have been looking at sexually assaulted children. It is clear to me now that being victimized in childhood has a lot to do with the child's mental health outcome" (Berliner, 1986).

Another area that society is not addressing properly is child neglect. Sixty percent of all substantiated cases of child abuse reported to the American Humane Association in 1980 were neglect cases. While there may be some question as to the motives of those who reported these cases (such as how many reports were moral judgements made by personally offended caseworkers or how many reports were made by those of higher socioeconomic status who were unable to understand the limitations and constraints in their clients' care of their children), neglect of children is still a grave social problem (Pagelow, 1984). And once again, society takes the "Band Aid" approach by offering food stamps and child welfare money, but doing little or nothing in the way of teaching parenting skills, providing quality day care, or making it easier for single parent women to get an education or training.

Still another area sorely ignored by society is sex education. Abortion is a stong emotional issue that's been debated again and again. Yet, society is unwilling to permit sex education to be a part of the public educational system, even though schools that have managed to initiate pilot programs have shown a great reduction in the number of unwanted teenage pregnancies. Nor have I ever heard of a social agency that has been set up exclusively for the distribution of free birth control measures or for providing free sterilization on demand.

One of the common characteristics identified again and again by social researchers in both child abuse victims and perpetrators is low self esteem. The time is far overdue for society to address this issue and initiate programs for both children and adults. One pilot program being used in the fifth grade classes of the Mobile Public Education System is "Meology." Designed as a drug abuse prevention measure, this program could easily be expanded to include all self esteem issues.

In the area of child battering, economic stress and psychological stress have been shown to be key factors. Yet, when a young mother comes to the "end of her rope" where can she go for help? Two of the goals of the Baton Rouge Child Protection Center are: to encourage the attainment of self-care status on the part of parents and to stimultate the attainment of self sufficiency for the family unit.

In Edmond, Oklahoma the First Presbyterian Church runs a Citizens Concerned for Children (CCC) Hotline 24 hours a day in their homes. Members offer information, advice, and refer callers to other sources for counseling or social services. In addition the volunteers work with the Foster Care Review Board making recommendations to judges about what seems best for a child who might otherwise fall through the cracks of an overburdened and underfinanced system. They also offer free programs on child abuse prevention to church and civic groups, provide a support system for foster families, run a toy and clothing program for

underprivileged children, give shelter parties for children who have been removed from their homes, provide educational and emotional support for 18 year old children who have been released from their foster homes, and provide a mother's day out program for parents who feel the stress and have to get away from their children for a little while (O'Roark, 1986). The question is what is society or the government doing to encourage the establishment of centers such as this throughout the country, and not just in Edmond, Oklahoma?

Dr.C. Henry Kempe (originator of the term "the battered child syndrome") says, "90% of the nation's abusive parents are readily treatable by reconstituting their sense of trust and by giving them considerable minute-to-minute support over a crucial period." He goes on to say the other 10% "belong to the catagories of abusive psychopathy or delusional schizophrenics who use a child as a scapegoat" and urges early removal of a child from the home in these cases (Helfer and Kempe, 1974). The "minute-to-minute" support would include guiding the parents to those social and welfare agencies that provide compensation for the physical needs of the family and those crisis centers that provide counseling for the psychological needs.

It all boils down to responsibility. Society expects parents (especially mothers) to be completely responsible for the care, training and education of their children--and that care, training and education must be of high quality and must meet tough societal standards. Sociologist Jessie Bernard points out that society gives mothers the exclusive responsibility for the care of children. That same society determines what is necessary for healthiest childhood development, but then makes it "as hard as possible to supply these essentials by making one person alone responsible for supplying them all by herself in an isolated household" (Bernard, 1975). When things go awry, society applies band aids, but is unwilling to take on the responsibility for changing the hidden, underlying problems.

Perhaps the greatest reason why we as a society should be concerned with child abuse has to do with the concept of the cycle of violence. This is the idea that the child who is abused will grow up to become an abusive adult--that violence begets violence. It is especially of great concern when it comes to child sexual abuse.

Dr. A. Nicholas Groth has worked with over 3000 sexual offenders in the last ten years. He has discovered that 80% of the sexual offenders he treated were sexually abused as children, and believes the other 20% were also, but are unable to disclose it. This is strong evidence in support of the cycle of violence. It doesn't imply that <u>all</u> sexually abused children will become abusers, but that the <u>potential</u> for a sexually abused child to become an offender is there.

Kenneth Lanning, Supervisory Special Agent for the F.B.I., reported at the recent Third National Symposium on Child Sexual Abuse that Dr.Gene Able's research on molesters over the age of eighteen indicated they had abused an average of 380 victims each. Kathy Love, Child Protective Services Supervisor, reported at the Child Abuse Prevention Seminar held in Mobile last September that perpetrators average 73 victims each. Even if you picked a number in between 380 and 73, say 100, then among 3000 perpetrators you could have 300,000 sexually abused children with the potential of becoming adult sexual abusers. Even if none of the victims became sexual offenders, as Lucy Berliner pointed out, there could be 300,000 children with the potential for having family problems, alcohol and drug problems, school failure problems, and suicidal tendencies. Add to this the potential problems of victims of neglect and battering, and we have painted a pretty miserable picture of the future society of America. And <u>this</u> is what the fuss is all about.

Definitions of Child Abuse:

One of the problems with studying child abuse has been the lack of uniformity of definitions. For the purposes of this paper, I have selected the following working definitions, based on those used by Child Protective Services (Caulfield, 1978).

Neglect is an act of omission which causes injury to the child. If the parents did not provide adequate care for their child because they were unable to do so, did not understand the need for the care, or did not have the parenting skills necessary to provide it, then this is termed neglect.

Physical Abuse is an act of commission which causes physical injury to the child. This could take the form of an actual physical attack or the purposeful withholding of food.

Sexual Abuse is the utilization of the child for sexual gratification or an adult's permitting another person to so use the child.

Emotional Abuse is the "mental injury" or deprivation suffered by children when their parents do not provide opportunities for the normal experiences producing feelings of being loved and wanted, secure and worthy, which result in the ability to form healthy object relationships (with other people) (Caulfield, page 2).

Child Abuse refers to the above types of abuse collectively.

Historical Perspectives of Child Abuse:

Child abuse is not a new phenomenon. Paleontological evidence, documentary accounts such as the Bible, even culture-specific myths and fairytales tell us of children being mistreated, abandoned, sacrificed, or eaten. Anthropologists have reported the disfigurement of children and the custom of infanticide in culture after culture (Finkelhor, et al. 1983). One common thread that travels down through the ages is the linking of

child abuse with law.

The Code of Hammurabi, established around 1770 B.C., is considered to be the granddaddy of modern day law. The Code made women and children the sole possession of the male head of the household to be used as he saw fit (Chambers et al., 1974). Severe forms of punishment were not only supported by law but were usually considered salutary. Ancient philosophers beat their pupils unmercifully. Parents, teachers, and ministers believed that the only cure for the "foolishness bound up in the heart of the child" was repression by use of the rod (Helfer and Kempe, 1974).

The ferule, a hardwood stick from the giant fennel tree, was used by Roman schoolmasters with severity. The Patria Postestas of the Romans endowed the father with the privilege "to sell, abandon, offer in sacrifice, devour, kill, or otherwise dispose of his offspring" (Helfer and Kempe, 1974).

In 1646 The Massachusetts courts adopted the Mosaic law, which imposed the death penalty on unruly children. Connecticut followed suit in 1651, but the law was soon substituted with public whipping (Helfer and Kempe, 1974).

By 1800 A.D. revolutionary legislation in France had emancipated women and children by establishing their civil liberties. Then Napolean established the Napoleonic Code in 1807, restoring the father's absolute authority in the family and taking away all the property and judicial rights that had been granted women during the Revolution (Chambers et al., 1974). This establishment of the patriarchy has remained a fundamental part of the legal system of western civilization to the present day, all in the name of social stability. It is little wonder that certain acts of abuse against children (and women) are considered legitimate after so many centuries of male authoritarian rule, unquestioning obedience of children and submission and deference of wives (Pagelow, 1984).

Penny A. McNees

Historical Perspectives of the Juvenile Court Sytem:

In the late 1800's the public finally became concerned about child abuse when the plight of a little maltreated girl named Mary Ellen made front-page headlines. Because there was no social agency yet established to help her, the Society for the Prevention of Cruelty to Animals (in existence since 1864) took up her case. This led to the founding of the Society for the Prevention of Cruelty to Children in 1874 and eventually to the first Juvenile Court Act of 1899 (passed in Illinois, a state which has continued to be a forerunner in child abuse legislation and which instituted the National Committee for Prevention of Child Abuse) (Pagelow, 1984).

The establishment of the juvenile court system was supposed to be a major breakthrough for children's rights to special treatment. The act's purpose was to protect juveniles from standing trials like adults and being sentenced to adult prisons.

As Fernandez writes, "Child saving with its overtones of paternalism permeated the thinking of the leaders who established the juvenile court system. Instead of locating the cause of delinquent behavior in the economic system that spawned unemployment and poverty, the architects of the juvenile justice system advocated 'reforming' the child in a residential setting away from the child's 'deprived' home and 'crime-infested' neighborhood. The decision about the child's future was placed in the hands of the 'benevolent' judge who was supposed to act in the child's best interest" (Fernandez, 1980). Thus, the results of the act were in fact a stripping away of constitutional rights from youngsters and a blurring of the line between children who were to be protected and those who were to be punished (Pagelow, 1984).

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Historical Perspectives of Child Sexual Abuse:

Phillippe Aries has written extensively on the evolution of social attitudes toward childhood. He notes a traditional indifference toward children in the Middle Ages and says the idea of childhood did not exist. Medieval art and iconography depict children as miniature adults, dressed in adult styles of clothing.

Not until the sixteenth and seventeenth centuries were children dressed in costumes that set them apart from the adults. It was then that a new concept of childhood appeared. Because of a child's "sweetness, simplicity, and drollery," children became a source of amusement and relaxation for adults. Thus, "coddling" replaced the more traditional indifference. It is easy to see how this concept of children being a source of amusement and relaxation could lead into the sexual abuse of children. There is evidence that this is indeed what happened.

The diary kept by the physician assigned to Louis XIII holds explicit details of the sexual abuse both endured and committed by the young dauphin. What is interesting are the different interpretations made by historians from this same primary source. Aries is inclined to slough it off as being part of the attitudes of the times. Other authors are more judgemental. It is my opinion that child sexual abuse has been around for centuries and it is only now that man's intellectual and cultural evolution has brought him to the point of facing the problem. Not only is he now cognitively mature enough to face the issue, but he has the mental capabilities of finding solutions to the problem. Just as we were incapable of flying to the moon at the turn of the century, so were we incapable of solving the child sexual abuse problem at that time.

To finish our look at history, by the seventeenth century, churchmen and moralists outside the family began to write and preach on a more realistic concept of childhood. Texts on child psychology and ways to correct the behavior of children appeared.

The moralists asked for more "disciplined rational manners" and were unwilling to think of children as "charming toys." This influence passed into family life (Aries, 1962).

In the eighteenth century these two elements (coddling and reform) were joined by concern about hygiene and physical health. This interest in healthy bodies had a moral purpose behind it in that a delicate body encouraged "luxury, sloth, concupiscence--all the vices in fact!" Fathers began to take a great interest in everything concerning his children's life and the child had taken an integral place in the family. An analysis of iconography shows that the concept of the family was unknown in the Middle Ages, that it originated in the fifteenth and sixteenth centuries, and that it reached its full expression in the seventeenth century (Aries, 1962).

From this brief look at history it is easy to see how child abuse has evolved over time. The law has given legitimacy to the actions of fathers by labeling children (and wives) as possessions. This hierarchical, patriarchal concept of the family is one of the most useful sociological explanations of the dynamics of child abuse in our society today.

Penny A. McNees

Psychological Aspects of Child Abuse

Psychology of the Victim:

When studying the psychology of the child abuse victim, it is important to keep in mind the stages of cognitive development in children. Children are not born with a completely developed brain. The brain must develop over a period of many years. It is estimated that 80% or more of the brain's reasoning intellect develops during the first seven years of life. As a result, children think differently.

Another area of development that takes time is language. Communication skills also develop slowly. Even if a child is aware of what has happened to him, he may not be able to express it. However, he may be able to show what has happened to him. That is why puppets, drawing pictures, playing with small figures, and working with anatomically correct dolls can make it possible for a child to communicate even though his language ability has not developed enough yet.

Many studies have been done by psychologists to understand the stages of development in children. Jean Piaget has identified various stages of cognitive development in his Biological Cognitive View. The sensorimotor stage (ages birth to two years) is organized around infants' physical and perceptual abilities. The preoperational stage (ages two to about seven) finds children trying to organize their information by grouping similar objects, ordering events in time, and explaining why things happened. Their reasoning is sometimes haphazard and illogical. The concrete operations stage (ages six to eleven) finds children learning to use rules and strategies for solving problems. Finally, in the formal operations stage (ages 12 to 18) they acquire abstract, logical systems of thought (Roediger et al.1984).

Our society, parents in particular, is sadly uninformed about child development, both physical (including sexual) and cognitive.

Parenting skills are not taught, they are acquired S.O.P. (seat of the pants). A lot of physical abuse could be prevented if parents were taught basic child development. A two year old is supposed to wet his pants. A three year old is supposed to ask "why?" fifty times an hour.

A program called "First Teachers" is being initiated in Missouri by Governor Christopher Bond. Parents are being taught parenting skills and basic child development in after-school groups in the public schools and at day care centers. An impact study in a few years may disclose positive results in reducing child abuse.

In the area of child sexual abuse, we turn to Freud for an understanding of psychosexual development. According to his theory, children from approximately 2 to 4 are in the anal stage, where they struggle for bowel and bladder control. In fact, children are working to develop control in general, trying to develop a sense of self and to exert control over aspects of their environment (MacFarlane et al., 1986).

Freud called the next stage of development the phallic stage (ages 4 to 6) during which they become increasingly aware of their genitals and of the differences between boys and girls. Masturbation and playing "doctor" or other exploratory games with friends and siblings may be seen during this time. According to Freud, children develop a clear sense of sex roles in this age range, and as they develop, they deal with their sexual feelings toward their parents through the Oedipal conflict in boys and the Electra conflict in girls. "A child develops a romantic attachment to the parent of the opposite sex and is disappointed when the parent does not respond to his or her overtures. The child then identifies with the parent of the same sex in order to become more attractive to the desired parent. Children at this stage may show versions of adult behavior, such as strutting and teasing in little boys and coy or flirtatious behavior in little girls. The identification with their same-sex parents helps children

strengthen their own sexual image" (MacFarlane et al., 1986).

It can be seen that the behavior of preschoolers in the phallic stage of development may raise issues that relate to possible sexual abuse. Professionals such as lawyers, judges, social workers, and therapists need to be aware of these behavioral tendencies for children in this age group. "If a parent is very needy and has trouble with boundaries in the family, he or she could easily misinterpret the child's Oedipal/Electra behavior as sexual attraction and might act on this misinterpretation in a way that leads to sexual exploitation of the child." Some flirtatious behavior may be normal during this stage; however, it is generally reserved for the familiar opposite-sex parent. If the behavior is indiscriminate, the possiblity of sexual abuse must be considered (MacFarlane et al., 1986).

The latency stage (ages 7 to 12) finds children's interest in sexuality less overt and with a decrease in sex play. Now dirty words and jokes hold considerable appeal. Freud's genital stage (age 13 and up) is when adult sexual interactions occur. When a child enters this stage, the cognitive and psychosexual development may come together, like a light bulb turning on, and the person may suddenly be aware of a sexual abuse experience that occurred many years before during their childhood. This awareness can be very upsetting and lead to depression or feelings of anger. Disclosure to a therapist or even just to a caring understanding individual can be very theraputic at this time and may counteract future maladjustments in sexual relationships.

The Psychology of the Offender:

Because of the work of such dedicated individuals as Dr.A.Nicholas Groth, a lot has been learned about child sexual abuse through the treatment of adult sexual offenders. Dr.Groth says sexual abuse is a cultural, social, political, legal, medical, economical, educational and spiritual issue. As a result,

it requires a multidisciplinary approach. In the late 1960's emerging feminists called attention to the plights of the victims. Help did not come from the professional community but from volunteers. Even today Rape Crisis Centers across the nation are staffed by volunteer counselors and much of the group work done by Dr.Groth depends on dedicated volunteers. One seemingly unapproachable child sexual offender was finally "reached" when he learned the lady conducting his group was a volunteer. When asked why he had suddenly started to cooperate with the group he said (of the lady), "Because she doesn't have to come down here to be with us. She's not even being paid. She must really care."

No one is more despised than the sexual offender. Dr.Groth says this is because ignorance leads to fear which leads to anger and then we get locked into our anger. The bottom line is we want to protect/reduce the risk of members of society becoming victims. How can we protect without addressing the elimination of the offenders? Decriminalize the offenders?

The problem is they are not all alike. Kee MacFarlane maintains there is no profile for a sexual offender because of the wide variety. One thing is for certain, the "sexually dangerous person" is likely to repeat the offense. Whether the offender should be treated as a patient or treated as an inmate, they need to be housed separately.

Also, intra-familial offenders may be able to be treated in a community-based outpatient center rather than in prison. Not only would this cut down on costs, but the offender would be more likely to come to treatment. If put with other felons, they are harassed so much they keep a low profile by not coming to treatment. However, they need to be mandated by law to ensure their cooperation.

Like alcoholism, sexual abusing is a compulsive behavior which needs continual treatment. There is no <u>cure.</u> Once an alcoholic, always an alcoholic. Once a sex offender, always a sex offender. But with continued group therapy, with an admission of

being responsible for their offensive behavior, and that they were wrong, and then apologizing to their victim for that behavior, there is a strong chance that the intra-familial offender can keep his compulsive behavior under his control. "What is becoming clearer, however, is that there is not an obvious distinction to be made between men who commit sexual abuse with their own children (incest) and men who commit sexual abuse with children outside the family" (Doolittle, 1986).

Dr.David Doolittle writes, "There are four common characteristics of intra-familial sexual offenders. The first is inadequate or weak object relationship. We see a clear lack of empathy in sexual offenders, and an unwillingness to recognize the emotional impact their behavior has on the children involved.

The second trait is a weak psychosexual identity. A lot of these offenders are macho looking and very controlling. But when one gets beneath that exterior and talks with these men about their experiences in sexual relationships (the psycho-sexual history), what you find is that they have experienced frustrations and disappointments.

The third characteristic is signs of unconscious homosexual strivings. This primarily relates to the weak psychosexual identity. Sex offenders should not be confused with homosexuals. These are two separate groups of people. Sexual abuse offenders don't have a clearly developed heterosexual pattern, even though they may have been married and may have families.

The fourth characteristic is that these men utilize projection as a major defense. This goes along with their denial and rationalization, blaming everybody in sight for the abuse coming to light" (Doolittle, 1986).

There are two general groups of intra-familial sexual offenders. One group is the very powerful, controlling, demanding man, who rules the roost and who doesn't want anyone to challenge his authority within the family. These men tend to be very distant, they don't have well-developed peer relationships, and

they generally don't experience closeness. The other group is passive and dependent and exists as part of the sibling system of the family. There is an overt dependency expressed in these men (Doolittle, 1986).

Dr. Groth has a typology of sex offenders which has been somewhat controversial. He makes a distinction between child molesters and child rapists. The key here is the difference in motivation or intent. The child molester wishes to achieve a safe, caring relationship with the child. This is expressed in a very distorted form, but this is what the man (or woman in a small percentage of the cases) hopes for. To the child rapist the child is seen as weak and helpless, and the intent is to dominate through physical force (Doolittle, 1986).

Dr. Theoharis Seghorn also worked at the same center as Dr. Groth--the Massachusetts Treatment Center at Bridgewater, Massachusetts. Here they have found that most child molesters abuse girls, but that 25% of the child molesters have an exclusive preference for boys, and 10% molest both boys and girls. The average age of the child molesters they see is just over thirty years of age. They also find a peak of child molesting in young adulthood and again in the middle thirties. Molesters are neither the senile dirty old man, nor the young adolescent. Also only 10% can be diagnosed to have a major mental illness, although most would be diagnosed as borderline personality disorders (Seghorn, 1986).

The majority of the child molesters, Dr.Seghorn goes on to say, are more likely to be very highly moral people in other aspects of their lives. They have a very strong, definite sense of what is right and what is wrong. The majority of child molesters who are repetitive (either with the same child or multiple children) have a distorted view of themselves and see the child as benefitting from the relationship. Very often in treatment, the molester will focus on the child victim's seductiveness, degree of experience, or degree of prior knowledge. "If you didn't know that

the victim was five years old, you'd be thinking that the molester was discussing a twenty year old adult. The molester sees himself as a child and identifies with the child that he is exploiting. In so doing, he manages to justify his sexual behavior to himself" (Seghorn, 1986).

One of the outstanding patterns identified by Dr.Groth in adult child molesters and rapists, has to do with the nature of the sexual act they perform with their victims. In case after case, the ritualistic pattern of the act matched perfectly with the pattern of the act of sexual abuse performed on them when they were the abused victim. If they had been sodomized, they were sodimizers. If they had been forced to perform fallatio as a child, then they forced their victims to perform fallatio. In one videotaped interview conducted by Dr.Groth, the offender described what his adoptive mother had forced him to perform on her--a ritualistic rubbing with his hands of the back of her legs, thighs and buttocks while she lay nude on her stomach. This practice was begun when he was a child of four and continued for many years. He admitted the practice was very comforting to him because it was the one time his mother wasn't yelling at him or beating him. He believed he was doing something that made her feel good, and that in turn made him feel good, too. Later, he was removed from the home because of his mother's abusiveness, and placed in a foster home in which the grandfather forced him to perform fallatio. As a young adult he began molesting children when normal life stresses became too much for him. And the act he performed on the children was the same identical ritual he once performed on his adoptive mother.

I believe very strongly that the keys to unlock the answers to the many questions we have about child sexual abuse are to be found in the sexual offenders themselves. Dr.Groth believes that the number of offenders with history of sexual abuse is even higher than the 80% which is currently thought. He says it is much harder for men to talk about having been sexually abused than it

is for women and girls. This is especially so if they were sodomized at the stage of development when they were struggling with sex role identity. Homosexuality is a grave fear in men. I believe that inside every sexual offender there is a child that was once abused, either sexually or from emotional neglect and deprivation or physical abuse by the father and/or mother. This is why it is becoming more and more important that we identify children that have been abused as soon as possible and get them into treatment--not only for their protection, but possibly for the future protection of society.

Bibliotherapy:

Bibliotherapy is one way of helping children who are victims of abuse to acquire coping behavior. Jerry J.Watson writes that a counselor may effectively involve the child with an emotional and psychological attachment to a literary character. The cathartic reaction of realizing that others suffer in much the same manner can be a respite from the isolation and suffering of abused children. The goals of bibliotherapy are: to teach a person to think constructively and positively; to encourage people to talk freely about their problems; to help people analyze their attitudes and modes of behavior; to point out that there is more than one solution to a problem; to stimulate an eagerness to find an adjustment to problems, an adjustment that will lessen conflict; and, to assist people in comparing their problems with those of others (Watson, 1980).

Bibliotherapy can be effective because books are dynamic and can bring about change in attitudes, habits, skills, and understandings of the people who read them. Fiction can benefit the child because its effect is immediate and intuitive rather than reasoned. The power in fiction allays guilt and anxieties and is an indirect means of dealing with problems that are frequently avoided. Fiction helps children accept themselves. The counselor

may insure such effects by carefully selecting novels that match the needs and problems of abused and neglectd children (Watson,1980).

The reverse can also be true. The reader may not accept a fictionalized character, may condemn the character and even reject the fiction. Stories may produce anxiety so great that the reader cannot harness it for verbal problem solving. Therefore, the counselor must take great care in choosing books for their child victims. Bibliotherapy does not offer a panacea or a substitute for the counselor's professional help (Watson, 1980). (A partial bibliography follows).

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Multiple Personality As A Response To Abuse:

Leigh Johnson was physically, sexually, and emotionally abused by her mother for sixteen years. Over that time she acquired seventeen different personalities. Becoming multiple is a defensive mechanism which enables an abused child to cope with the abuse and which becomes dysfunctional over time. Each personality had a separate name (and a separate wardrobe!). By the time Leigh was able to get help, she was thirty five years old, depleted, mousy, with low energy, extremely low self esteem, and could not look anyone in the eye. She was also a chronic complainer.

Her doctor was Gary Porier, a clinical psychologist in Huntsville, Alabama. Together they went through 407 sessions of one to two and a half hours each over a four year period of time.

It took three and a half years before Leigh was able to trust him enough to tell him everything. The sessions were very painful for her.

I first heard Leigh speak as a member of the victims panel at the Statewide Sexual Assault Workshop held in Mobile in May 1985. Hers is a story of unbelievable horror, but is one which can give us great insight into how an abused child's mind operates.

Leigh's mother was a beautiful and talented woman whose mother wouldn't permit her to sing with the New York Met. She came from an upper class family and had debuted in society; she married Leigh's father just before he became mayor of South Miami. The family was very well off financially. Leigh's mother became an alcoholic and a perscription drug abuser (at her "peak" she went to 28 different doctors to get perscriptions). She spent a lot of time in and out of mental hospitals and had had shock therapy. She was eventually diagnosed as paranoid schizophrenic.

Leigh was the third and youngest child, with a sister ten years older, and a brother five years older. As near as Leigh can remember, she was the only child that was abused, although she said her sister wouldn't allow herself to be hugged or kissed and she thought there was a romantic relationship between her mother and her brother.

Her first personality was Susie, the child of two and a half to four years of age. It was during this time that Leigh's mother began to scrape Leigh's vagina with a toothbrush and then pour alcohol into it. Other personalities were Candy (the five year old) and Yvonne (the nurturing personality). Each personality had a job. One was the holder of Pain, one of Anger, and one of Fear.

The "core" Leigh did not know she was being abused. At the age of twelve her mother prostituted her out to a dentist in order to gets drugs. When Leigh became pregnant, her mother took the brace off the back screen door and aborted the fetus. She then took the fetus and smeared it all over Leigh's body. Leigh took on two personalities at that time--both took on the job of Guilt.

Today Leigh tells how the child in her responded to the abuse. She tells how disassociation is the best defense for a child; how she had no support system but herself; how she had no choice; how she thought to tell the truth was bad, and to tell a lie was good; how her mother aimed a gun at her eye and told her never to tell anyone; how her response to the abuse was that she thought she was an accomplice to the act and that she had caused it; and how that was worse than the abuse itself.

She tells about the time her father caught her mother and she in the act of "mutual" masturbation and just walked away. Later he told her he didn't do anything because "she was so beautiful and you were so strong."

About three years into therapy, Leigh's mother had a heart attack. The doctor encouraged Leigh to confront her mother before she died. With her dying gasp, she snarled and spit in Leigh's face. Leigh's father died of a stroke shortly after. So, both parents died before Leigh could resolve anything with them.

Leigh campaigns today on behalf of abused children everywhere. She worked very hard to get the National Child Advocacy Center established in Huntsville, Alabama, and is the Outreach worker on the staff. Everywhere she speaks, she quotes John Walsh (father of victim Adam Walsh) saying, "We are all responsible for all children all the time."

Penny A. McNees

Biological Aspects of Child Abuse

The Theory of Evolution:

According to Robert L. Burgess and James Garbarino, given the long history of child abuse as well as its generality across cultures and species, the modern theory of evolution is sufficiently general to permit "parsimonious interpretations of the diverse data currently available" and yet "is precise enough to generate specific predictions" (Finkelhor et al.,1983, page 90). They base their position on life from the beginning of time being subjected to a continual process of natural selection or differential reproduction. They go on to say that on the average, individuals better adapted to their physical and social environment have higher fitness (Finklehor et al., 1983).

The behavioral responses to physical, biotic, or social stimuli necessarily affect the likelihood of gene replication. Burgess and Garbarino maintain that "because behavior results from the interactions among genetic, developmental, and situational factors, child abuse may have a heritable basis and thus a relation to evolutionary processes" (Finklhor et al., page 91).

As a student of biology, I must admit (regretfully, hesitatingly) that these ideas have crossed my mind, too. What if there is a heritable link to the "cycle of violence?" Or worse still, what if child abuse is a check built into the natural scheme of life to insure the survival of the fittest? Are we playing God with our crisis intervention work and our treatment programs for child abuse?

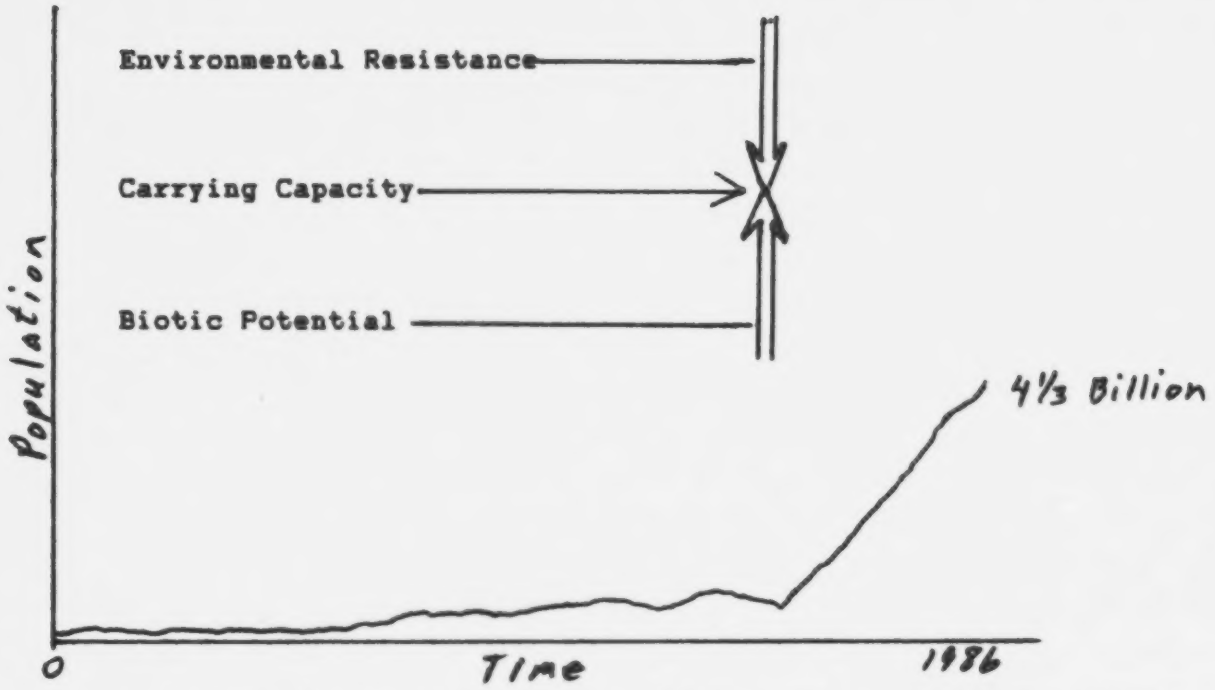
Burgess and Garbarino base their position on two particular concepts of evolutionary theory: parental investment and parental certainty. Parental investment refers to "behavior displayed by a parent that increases the reproductive potential of the child toward whom the behavior is directed, at the cost of similar investment by the parent toward other or future offspring"

(Finkelhor et al. page 92). This includes the idea that a parent has limited resources and a finite life span in which to expend those resources in the rearing of children.

The second concept, parental certainty, implies parents might adaptively discontinue or diminish their care of children if they are of doubtful parenthood. It also implies that parental care appears to be selective, and parents don't want to run the evolutionary risk of investing in offspring who share none of their genes (Finkelhor et al, page 93). The implication here is frightening in view of the high divorce rate and multiple "his, hers, and ours" families in our society today. It also lends insight into why bonding of both parents with the newborn is so important and why child abuse is so common among step-fathers and step-children where bonding has never occurred.

Another biological concept that has possible applications with child abuse is the general law of population dynamics. This theory maintains that for a particular habitat there is a particular population size that can be supported by that habitat. Included in this law are three factors: biotic potential, environmental resistence, and environmental carrying capacity.

Biotic potential refers to the tendency for a species to reproduce and increase in number. In other words, the tendency for a species to produce too many offspring. Environmental resistence is the sum of all of the factors (predation, disease, accidents, catastrophes) that tend to decrease population size. Environmental capacity is the maximum number of a species population the resources of an environment can maintain successfully (Wallace et al., 1981). (See chart that follows).



Included also in this law are three other factors. First, healthy populations never double or go over their carrying capacity. Second, whenever a population excedes its carrying capacity it tends to degrade or destroy part of the habitat. And third, every advance made pushes back environmental resistance (Wallace et al., 1981). By following through with this line of reasoning, we have no alternative but to conclude: If we interfere with the environmental resistance on the population of our world, the human species will eventually become extinct. What if child abuse is part of the environmental resistance? Are we playing God?

Cultural Evolution:

Before we throw up our hands in horror at the line of reasoning I'm taking, let's look at evolution from another standpoint. Theodosius Dobzhansky writes that Homo sapiens stands alone in organic nature with respect to the forces of natural selection. He maintains that biological evolution has surpassed itself in the emergence of man. This excellence in evolution (or

evolutionary uniqueness) means that the degree of man's adaptive success is now determined by his capacity for culture rather than (as with prehuman forms) genetic mutation (Dobzhansky 1961).

Dobzhansky goes on to say "By changing what man knows about the world, he changes the world he knows; and by changing the world in which he lives, he changes himself." This is cultural evolution, and human cultural evolution has resulted in the formation of a system of human values. An ancient Chinese sage proposed, "Every system of moral laws must be based upon man's own consciousness, verified by the common experience of mankind, tested by due sanction of historical experience and found without error, applied to the operations and processes of nature in the physical universe and found to be without contradiction, laid before the gods without question or fear, and able to wait a hundred generations and have it confirmed without a doubt by a Sage of posterity" (Dobzhansky 1961).

Should we play God? Should we wipe child abuse in all its ugly forms from the face of the earth? The answer according to Dobzhansky is a resounding "Yes!" If God made man in the image of Himself, did He also not give man the same cognitive potential--the same Power with which to rule His world?

Dr.W.Hall Calvert said it best, "Humanity has therefore every reason to hope, 'to greet the unseen with a cheer,' for who can limit the summit of attainment when a perfect environment has become possible to all members of the species, by means of the operation in men's minds of the sublime thought and altruism of the New Testament, directing the progressive spiritual evolution of the race? May we not in its completion be able to say of the whole human family, to borrow the sublime apostrophe of Hamlet: 'What a piece of work is Man; how noble in reason; how infinite in faculty; in form, in moving, how express and admirable; in action, how like an angel; in apprehension how like a god; the beauty of the world; the paragon of animals!" (Calvert 1908).

Penny A. McNees

Acts of Commission; Acts of Omission:

One of the most insidious forms of child abuse to surface in recent years is Munchausen Syndrome by Proxy. The term Munchausen Syndrome was given to adults who produce false histories and fabricate physical signs and laboratory findings, causing themselves needless medical evaluations, operations and treatment. Unlike hypochondria, these individuals were actually producing physical problems for themselves and making diagnosis by their doctors very difficult (Jones, 1986).

In 1977 Dr. Ray Meadow coined the term Munchausen Syndrome by Proxy when describing a six year old girl who had recurrent bloody urine with repeated hospitalizations and tests all her life to find the cause. The urine findings were spurious, produced by the child's mother. He has since diagnosed 76 cases with the problem, one fourth of them with intentionally caused seizures (Jones,1986).

Parents have contaminated laboratory specimens with blood obtained from their own fingers; have added salt or fluids to their children's blood specimens; have induced illnesses by poisoning with readily available medications; and have produced diarrhea by excessive administration of laxatives (Ex Lax with phenolphthalein being the most common). They have produced polymicrobial bacteremia by injecting contaminated fluid into their children's intravenous tubing; and have induced cardiorespiratory arrest by suffocation (Jones, 1986).

Some children die as a result of induced illness (10% in one series of cases). In one case, further history revealed several instances of psychiatric care of the mother, pseudosiezures and previous nursing training. Two other adopted children of the mother had died at less than one year, and another adopted child had been removed from her custody. All three children had had similar episodes of vomiting and diarrhea.

The child victims that have been reported range in age from

infancy to eight years. The perpetrators are usually the mothers, frequently reflecting prior nursing training. When confronted with the possibility of their child having Munchausen syndrome by proxy, the parent is likely to deny it, but some parents admit their guilt with relief. Some then accept psychiatric intervention, while others have been known to attempt suicide, become psychotic, or seek surgical procedures for themselves (Jones, 1986).

Interestingly, the mothers are usually so convincing that the nurses in the hospital come to their defense when Munchausen Syndrome by Proxy is suggested by the physician. The mothers usually give the impression of being very loving and caring.

Diagnosis can be made when medical and social histories are characteristic of the syndrome and clinical findings are absent or resolve when the child is kept separated from the parent. When diagnosed, the case should be reported under the child abuse reporting law of the state and court intervention should be considered (Jones, 1986).

While this syndrome has been considered rare, cases may have been overlooked in the past. However, the incidence may be increasing because psychosocial disorders are affected by changes in society and the structure of families. Health care professionals involved with children need to be aware of Munchausen Syndrome by Proxy (Jones, 1986).

On the opposite end of the spectrum are the acts of omission--cases in which medical treatment for the child is not permitted because of the religious beliefs of the parent. The deaths of sixty-seven children in Ohio, Indiana, Illinois and Michigan in the last three years have been attributed to the withholding of medical treatment.

In 47 states parents are still allowed to prevent their children from having medical treatment because of religious beliefs. In Ohio a landmark decision may be in the making. Two

parents of the Faith Assembly Church allowed their two year old daughter to die of bronchial pneumonia (a curable disease), because they wouldn't permit medical treatment. They have been charged with murder. Again if we look to the past, we can see why these laws are still on the books.

Prior to the 1800's medical treatment consisted of very dangerous practices. Leeching or blood-letting, surgery without benefit of anesthesia or disinfectants, even superstitious witchcraft were all that physicians were capable of doing in the way of treatment for their patients. To be treated very often was worse than to be left untreated. It is understandable that some religious sects would incorporate these acts of omission in their edicts.

It is time that those religious faiths of today that still hold to these beliefs matured in their cultural spirituality. Withholding medical treatment from sick and dying children in the name of religion is physical child abuse. This should not be tolerated in modern society (based on a report made on the "Today Show" on March 2, 1987).

Collecting Medical Evidence:

From the National Center for the Prosecution of Child Abuse, based in Alexandria, West Virginia, we are told there were 1,712,641 reports of abused and neglected children made in the U.S. in 1984. This was an increase of 16% over those reported in 1983 and an increase of 158% over those reported in 1976. Sexual abuse reports rose 59% from 1983 to 1984 with some states reporting even higher rates. In reviewing reports received by the American Humane Society's Clearinghouse on Child Abuse, it has been estimated that 60,000 to 100,000 children are sexually abused annually in the United States; with this incidence, it would appear 10-14% of American families are affected by child sexual

abuse each year (MacFarlane et al., 1986).

According to most experts, these numbers represent only a fraction of the actual extent of abuse and neglect. Child abuse reporting is now mandatory throughout the U.S. with fines of up to $500 and six months in jail for failure to report. Still, countless cases go undocumented because of failure to report or to conduct adequate investigations.

The number of child abuse cases coming to the attention of prosecutors have significant implications for criminal justice. Outdated court rules, traditional investigations, trial techniques, and use of hearsay evidence have all come into question as courts confront more and more cases in which the only witness is a child. Until such change occurs in our courts, we must learn to work as successfully as possible within the system. Medical evidence and medical expert testimony is still the major component for successful prosecution in a child abuse case.

While medical evidence of physical abuse and neglect is easily confirmed (by the use of x-rays for broken bones, photographs of macroscopic injuries (bites, scratches, bruises and contusions), and laboratory tests proving the existence of malnutrition or disease left unattended), sexual abuse in children is more difficult to assess. This is because the abuse in the majority of cases in children under six does not involve penetration.

The type of sexual activity of the offender ranges from hand-genital contact, to oral-genital contact, to attempted penetration, to penetration. Sometimes there is no physical touching, only visual or verbal contact. In preschool children the activity is usually limited to hand-genital manipulation or oral-genital contact, because of the small size of the genitals. Penetration is very rare. Even in cases where the child has contracted gonorrhea there has been no penetration. Instead, the offender has rubbed his genitals in the area of the child's genitals. Sometimes penetration is made by the finger only

(Burgess et al., 1978).

The offenders are usually known by the victims. In the Huntsville study (see Appendix F) only 8% were strangers and 8% were unknown. It has been found that 75-80% of sexual abuse occurs within "affinity systems"--families, relatives, friends, and neighbors (MacFarlane et al. 1986).

Medical evidence of child sexual abuse includes conversion indicators (stomach aches, constipation), infectious indicators (urethral, genital-vaginal, sore throats), trauma indicators (genital, oral, or anal lacerations or loosening of the anal sphincter muscle), and reactive-affective or reactive-behavior symptoms (mood disorders, anxiety reactions, poor school performance,etc.) Non-congenital venereal disease in pre-pubertal children should be considered virtually absolute evidence of sexual abuse. Foreign bodies found in the genital area should be assumed to have been placed there by others until proven differently. Children who place foreign bodies in anal, urethral and vaginal orifices may be victims of sexual overstimulation (See Appendix E).

Use of the Colposcope and Dye:

Seventy-five percent of children who report painful genital or anal penetration by a penis, finger or instrument will have overt or subtle findings of sexual abuse. When acute, these findings will include abrasions, transections, contusions, etc. Chronic or old findings present as focal scarring, hymenal deformity or hymenal thickening with scarring.

The colposcope is an instrument which employs a binocular system with 5X to 30X magnification potential. Primarily used for early diagnosis of cervical cancer, it has recently been introduced as a tool for clarifying the diagnosis of sexual abuse. Dr.Bruce Woodling and Dr.Astrid Heger have been using the

colposcope to detect genital microtrauma since 1982. They have found that an additional 10% of cases are identified which would have been missed using macroscopic examination only (Woodling and Heger, 1986).

Additional benefits of using the colposcope are: providing an excellant light source, creating an environment in which the examination is done with care and attention to detail, and it can be equipped with a 35mm camera for documentation of physical injury. Also the colposcope is a noninvasive instrument which has proved nonthreatening to children in the pediatric age group (Woodling and Heger, 1986).

Another tool that has proven to be useful in gathering medical evidence is the dye toluidine blue. Dr. Micki Cabaniss has used the dye with much success in identifying forced penetration where macroscopic evidence is missing. A 1% aqueous solution of toluidine blue is applied to the fourchette below the vaginal area with a cotton tip applicator. Irregular stelate marks will retain a deep blue stain if trauma has occurred (Cabaniss, 1985).

The use of a dye has also been used at the University of Maryland Hospital to diagnose child sexual abuse in small children. Their dye is similar to the ink once used in cartridge pens, and is easy to apply, inexpensive and has no side effects. Among sexually abused children, the detection rate increased from 16.5% to 33%. In sexually abused adolescents from ages 11 to 18, the detection rate rose from 4% to 28% (Mobile Press Register, 12-27-86).

Penny A. McNees

Child Advocacy--What Is It?

Although people have been acting in the best interests of children for sometime, it has only been since the passing of the Civil Rights Act of 1964 and the following landmark legislation of the late 60's and early 70's (such as the Gault decison of 1967 giving due process rights for juveniles in delinquent hearings and the Child Abuse Prevention and Treatment Act of 1974) that the terms for the practice (child advocacy) and the practitioner (child advocate) have been used extensively. Happy Craven Fernandez writes in his Child Advocacy Handbook "a child advocate is an actor on behalf of children" (Fernandez, 1980).

When a person takes on the role of child advocate, he/she becomes a defender, protector, mediator, supporter, investigator, negotiator, monitor, promoter, enabler, and/or counselor for children. A child advocate accomplishes this by moving bureaucracies and changing systems (Fernandez, page 13).

A major function of child advocates is seeing that institutions are more responsive to the needs of the children that they were set up to serve. Children's rights are gaining the attention of professionals in the fields of education, justice, mental retardation, child abuse, health, television and many others. Children's rights to quality services and due process procedures are the central issues in the debate over the kind of special protection that children need. "Engaging in that debate is a first step toward changing attitudes and actions affecting America's children" (Fernandez, page 59). This can be approached in two ways: by obtaining more responsive, adequate and effective services for children and their families, and by developing the strengths, initiatives, and skills of those families so that they can solve their own problems and be their own advocates.

The child advocate also aims at changing systems rather than focusing exclusively on individual case problems. While it may be necessary to begin by focusing on a specific child that needs help

(case advocacy), the ultimate goal is to alter the systems to make permanent changes that will benefit all future children who use the systems (class advocacy). Therefore, case advocacy is used as the basis for identifying and documenting the places in the system where children are being poorly served and then pressing for changes in policies and procedures in the whole system (Fernandez, page 22).

From the national child advocacy study done by the Department of Health, Education and Welfare, it was determined that child advocates can bring about change by focusing on several areas. Some of these are policy changes, specific personnel, budgets, new programs, law, political action, and physical and environmental conditions.

Policy changes can be affected by such actions as changing the character of a program, the rules of a game, or the eligibility requirements. Specific personnel can be replaced (or performance corrected) by focusing on alleged malfeasance or nonfeasance on the part of a school principal, teacher, case worker, aide, inspector or the like. Budgets can be addressed by focusing on the assurance of adequate appropriations.

If there is a need for a new program, major changes in an existing program, or elimination of an existing policy, the advocate may target on changing the law. Advocates often lobby for or against legislation on behalf of children. Sometimes they turn over proposed legislation to members of the executive or legislative branch for formal introduction. Other times the issue is fought in the courts, such as using a client's case as the vehicle for a "class action." A "class action" is a legal challenge that, if sustained, invalidates a law or leads to major new administrative departures.

Child advocates may also make up political action groups. Here the ultimate goal is redistribution of power and resources on behalf of children.

Physical conditions may also be addressed, such as the

physical layout or condition of a school, detention center, hospital, home, clinic, or playground. Also included here would be the wider physical environment, such as traffic patterns in a neighborhood, planning of apartment complexes and shopping centers, or pollution of rivers or air (Fernandez, pages 26-28).

The child advocate is not any and everyone working with children or in children's services. In other words, he/she does not necessarily provide direct services. Instead, the child advocate is the person acting on behalf of children to see that institutions and systems serve children's interests. "The advocate monitors human services but does not provide them" (Fernandez, page 91).

A person's primary role may be as a parent, teacher, child-care worker, nurse or social worker and they may function in that role most of the time. But when specific action for the best interest of children is needed, he/she steps into the role of child advocate.

A child advocate is not a "child saver." The paternalistic attitude of the child saver too often creates a dependency relationship that undermines the goal of equipping the child or the child's parent to negotiate the system and become his/her own advocate. The child saving mentality can prevent the advocate from making systems changes that would enable the child or the child's parent to be listened to and respected as a person with feelings, opinions and rights. The well-intentioned "child savers" often do something for the child rather than on behalf of the child (Fernandez, 1980).

A child advocate is a caring, knowledgeable and active person. A child advocate cares by being aware of his/her own value system. The advocate wrestles with questions such as: What power do I have as a parent, neighbor or citizen? How far does my responsibility extend? What forces go beyond my role and control, and how can I enlist the support of those persons and groups who do have the power to make those changes?

Added to caring is knowledge. An advocate must know the facts of a specific case and what results are wanted. He/she must know how the system or systems function and how to impact upon them. The advocate must know how to document facts and evidence, must understand the rights of children, and must be aware of what other child advocates and organizations are doing.

Finally, an advocate acts. The child advocate's commitment to children moves him into "using facts as the basis for action, and using action to uncover more facts." It is important to begin with the roles and situations where we find ourselves rather than waiting for the "perfect moment, the foolproof strategy or the charismatic leader." In addition the child advocate should be willing to take some risks, be flexibile, learn from mistakes, and be persistent (Fernandez, page 61).

Now that we have established what child advocacy is and what a child advocate does, let us examine what a child advocacy center is and the pivitol part it can play in child abuse prevention. We will look at the purpose of the facility, the programs that might be initiated there, and the effects a center might have on a community. In addition, we will incorporate guidelines that may be followed to establish such a center.

Penny A. McNees

Introduction

Those of us in Mobile are very fortunate to have the Huntsville, Alabama National Children's Advocacy Center based in our state. Not only will our center come under the same state laws, and the same state agencies, but we will also be in a good position for state funding when it becomes available. Funding is a major problem and I will not include much information about it in the following guidelines. However, I will mention that at the recent Third National Symposium On Child Abuse, held in Huntsville, it was announced at the special session following the symposium that Governor Hunt was seriously considering appropriating one million dollars to be split between the child advocacy centers in Huntsville, Birmingham, Montgomery and Mobile. This funding will prove very helpful in the running of the center in Huntsville, and the establishment of the centers in Birmingham, Montgomery and Mobile. Birmingham's center (Prescott House) is just about to open; Mobile's center has just been purchased; and Montgomery is still in the Task Force stage.

The guidelines in this report are based very heavily on the Huntsville program. I take no credit for the creativity behind the guidelines, only the organization of them.

What is a child advocacy center?

A child advocacy center is a facility that provides a non-threatening environment for children who have been victims of sexual abuse or severe physical abuse. An old comfortable house of about nine to eleven rooms makes a perfect child advocacy center in this respect.

The child advocacy center also provides a "neutral territory" where representatives of the various agencies can come to discuss, evaluate, assess and interview abused children. Turf issues are the biggest handicap in the implementation of the

multi-disciplinary program. The center also provides a room where the weekly team review of abuse cases can take place.

The center helps put an end to "agency bouncing" by providing one place where the child comes to be interviewed by the necessary agency representatives. The center can also be utilized for the treatment of the child and the family by the inhouse therapist or by referral therapists. The Huntsville board of directors is presently looking for another house to serve for the treatment of children and their families. The center does not coordinate the treatment of perpetrators.

A child advocacy center can also provide housing for the community's child abuse prevention educational materials (books, video tapes, films etc.). A speaker's bureau and community awareness programs can be coordinated from the center.

The center is <u>not</u> a shelter. One thing to keep in mind: a child advocacy center is not a place that provides services, but a place where services are coordinated. Fernandez writes, "the great danger of model programs is that the social change organizaton will turn into a service provider and lose its status as organizer and advocate. If your group becomes a service provider, you will probably not help to promote change. Rather, you will be taking the pressure off of the other service agencies because you are providing the services that they should provide. If there is a need for new service agencies in the communtiy, you should organize these separately from your advocacy program so as not to confuse advocating with providing direct services. <u>The advocate (advocacy center) monitors human services but does not provide them</u>" (Fernandez, 1980).

Probably the most important function of the child advocacy center is making sure the child's best interests are being provided for. This is especially true if the child must be a witness in criminal court. The center provides a non-threatening atmosphere for the child advocate to work in when preparing the child for court. Too often the child has been retraumatized by

having to participate in criminal court without any consideration for their feelings, opinions or rights.

Penny A. McNees

Guidelines For Establishing A Child Advocacy Center

The Board of Directors:

A Board of Directors should be appointed from among the various agencies and community leaders committed to the multi-disciplinary child advocacy program. A president, vice-president, secretary and treasurer should be elected. Committees should be set up to purchase a facility, seek funding, write by-laws, provide community education, and write publicity. Establish a name and logo for the center and purchase letter-head stationery. Become incorporated and get tax exempt status.

Basic philosophies of the program should be outlined and put in writing. These could include:

All agencies will work in the best interests of the child.

The program will provide a home-like setting in which to bring services to the child.

The program will enhance interagency communication and cooperation.

The program will enhance and refine professional skills necessary to handle sexual abuse cases.

The progam will protect the child from further abuse.

The program will hold the offender accountable.

The program will assist the family in regaining maximum functioning.

The Board of Directors should outline goals for the program. These could include:

To improve the quality and responsiveness of all systems involved with sexually abused children.

To eliminate the revictimization of the abused child.

To improve the coordination between agencies in handling cases.

To increase all participant's understanding of the criminal justice system.

To improve the skills of all.

To create a similar perception on the part of all professionals (protecting the child and punishing the offender).

To share the responsibility and relieve the total burden from one agency alone.

To increase the prosecution of offenders.

To serve the community better as well as the children and their families.

To show children that the system can work for them.

The Interdisciplinary Team:

The heart of the program is the system of case review. The interdisciplinary team meets once a week to review new cases of child sexual abuse and severe physical abuse, and to review cases that are pending. Once a month they meet on a supervisory level to review protocols; once a quarter they have a workshop. Cooperation is vital to the program. Therefore, you need to get written interagency agreements. Protocol (procedures for handling cases) should be in writing between all participating agencies. You need a systemic protocol and then a protocol within each agency. That protocol should be established but still flexible. (See Appendix B for flow charts).

The team members consist of representatives from the D.A.'s office, CPS (DHR), law enforcement (city and county), mental health and victim witness advocates. They serve in the following roles:

Assistant District Attorney: Placed on the team by the District Attorney's office, the Assistant D.A. chairs the team meetings and refers (and coordinates) cases for prosecution to the D.A.'s Child Abuse Prosecution Unit. The same Assistant D.A. follows a case from beginning to end and beyond if retried. The

Asst.D.A. provides legal advice and expertise in the disposition of cases.

DHR Social Worker: Placed on the team by the county office of the state Department of Human Resources, Child Protection Division, the social worker coordinates the involvement of her department in the Child Advocacy Center program. She/he is directly involved with the interview, the intervention, and the investigation process, and participates in all team meetings. The DHR attorney doesn't participate in team review.

Law Enforcement Detective: Provided by the police department, the detective coordinates the involvement of law enforcement in the Center program. The detective participates in the team review, and is directly involved in the interview, intervention and investigation process. The same investigator stays with the case all the way through.

Mental Health Therapist: In Huntsville, the center has an in-house therapist who maintains an office at the center where all counseling occurs. The therapist participates at all team review meetings. No child witnesses in court until the therapist says the child is ready.

Victim Witness Advocate: The Victim Advocate participates in all team meetings and prepares the children and family for participation in the criminal justice system. She/he coordinates the Victim Advocate Program of the D.A.'s Office and assigns the child advocates who accompany the victims and their families during all stages of the criminal prosecution process.

Pediatrician: The Huntsville Board of Directors has a public health pediatrician who does the medical history and examination for most of the abused children. She has also been trained in the criminal justice procedures and knows how to be an effective expert witness. Because of the time involved in providing medical expert testimony, most physicians avoid child abuse cases. The Center cuts a lot of the waiting time for the pediatrician by keeping her informed of how the case is proceeding and then just

before it's time for the doctor to take the witness stand, the Center sends a car to pick up the doctor. After the doctor testifies, the Center returns her to her office. The doctor does not participate in team review.

The Staff:

The staff of the Huntsville Center consists of an administrative assistant who is the center manager and coordinator, a secretary, a staff therapist, and an outreach person. Their roles are:

Administrative Assistant: The Administrative Assistant is responsible for the day-to-day operations of the Center, particularly ensuring the proper flow of cases through the Center. She also maintains all financial records, assists in local fund raising activities, and provides technical assistance. Because the Center is available 24 hours a day, 7 days a week, she may be called upon to open up the center when necessary.

Secretary: The secretary performs all clerical duties, keeps the Center schedule, maintains all files, and serves as "hostess" to the children and professionals using the Center.

Staff Therapist: The Staff Therapist serves on the Interdisciplinary Team, maintains an office at the center, runs group therapy sessions, and provides therapy for the children and adolescents. She also works with the families. The mental health community is dangerously uninformed about the criminal justice system. The Staff Therapist is now the bridge between.

Outreach Person: The Outreach Person serves as liason to the community, contributes to training and education activities provided through the center, and makes speaking engagements to civic organizations.

The Facility:

Purchase an older home of nine to eleven rooms that can

provide a non-threatening environment for children, as well as accomodate the staff with professional office space. The facility needs to be near the bus line, and convenient to the courthouse, the police department, the District Attorney's Office, mental health center, and child protective services offices.

The center should be an interview assessment facility, providing a non-institutional setting. The tone of the entire facility should be designed to convey to the child that he or she is important to and respected by the adults who work there. The Huntsville Center includes plants, rocking chairs, a porch swing, a wide variety of toys, and an aquarium to suggest a warm and caring environment.

The Huntsville Center opened with only three rooms furnished: the greeting/living room, and two interview rooms. The Center now also contains a conference room for team review meetings, interviews, staff meetings, and educational sessions.

Most of the rooms are multipurpose and can be used for work rooms for visiting professionals or for interviewing. Built-in desks and shelving units are used to save space. There is a small kitchenette which utilizes a long wall for the children's art work. There is also a secretary/receptionist area around the corner from the greeting/living room. The greeting/living room can also be used for group therapy sessions.

The Coordinator's office was specifically designed to facilitate family conferences. The adolescent room provides an excellent atmosphere for individual therapy, and the children's interview room is well equipped for play therapy. (See Appendix A for photographs of the exterior of the new Mobile Child Advocacy Center and pictures of the exterior and photographs of the interior of the Huntsville Center).

Cost of Operations:

The cost of operations to run the Huntsville Center is

approximately $175.000 per year. This includes the salaries of the four staff members, lease purchase of the house, utilities, etc. The Birmingham Center's Administrative Assistant/Coordinator makes in the low 20's and the secretary is paid around 14,000 (based on the civil service scale). The furnishings for the Huntsville Center were provided by the community. Funding for the Center comes from federal money, community funding, private donations, and donations from civic clubs and organizations.

Data Collection For Comprehensive Evaluation:

A program has to be accountable for its resources. Comprehensive Evaluation is the ideal type of evaluation for a program in that it combines monitoring, impact assessment, and ex post benefit or cost effectiveness analyses. The purposes of this type of evaluation are to determine whether the program is carrying out the treatment as planned, whether it resulted in changes consistent with the intended outcomes, and whether the program funds were used efficiently.

Eventually, the Child Advocacy Program will need to be evaluated--possibly as early as the end of the first year. It would be wise to hire a social scientist (evaluation researcher) to do this evaluation. While this may cost more initially, the credibility of the final research report would aid considerably in the acquisition of future funding. The Sociology Department of the University of South Alabama under the chairmanship of Dr. Richard Wells would be a perfect contact for this work.

The goal of a social scientist is to conduct research that will somehow improve society. The researcher is obliged to perform the research under acceptable standards and is responsible to the goals of the organization being studied.

For the impact part of the study, a set of goals and the criteria for success of a program will need to be specified for the researcher. Then the researcher will establish whether the program

is causing a change in the appropriate direction and if these changes are due to the program and not outside influences.
The following questions should be asked when doing an impact assessment: Is the program effective in achieving its intended goals? Can the results of the program be explained by some alternative process that is outside of the program's design? And is the program having some effects that were not intended?
Keeping these points in mind, it would be of great benefit to build into the system initially a unified means of data collection. This would require well-designed forms and a properly trained staff to complete these forms and to ensure that quality data are collected. All data collection activities should be conducted so that the rights, welfare, dignity and worth of individuals are respected and protected.
The success of evaluaton research stems from a growing commitment to orderly policy development. The consequences of evaluation research are a growing recognition of the importance of policy planning and program implementation so that the fate of target populations is not just dependent upon emotional appeals and arguments of persuasion. While the objectives of research are to gain knowledge and understanding, the goals of human service agencies are to alleviate social problems (Formichella, 1986).

Synopsis:

1) Write a set of goals and criteria for success of the Child Advocacy Program.
2) Design a uniform set of forms for data collection. (See Appendix C and Appendix F for sample forms).
3) Develop a training program (or written brochure) to instruct the staff on the completion of these forms.

Insurance:

A homeowner's policy covering the replacement value of the center and its furnishings should be purchased. A high deductible will keep the premium payments lower. As for liability insurance, the four staff members of the National Children's Advocacy Center in Huntsville are considered to be county employees and therefore, fall under the county's umbrella policy.

Library for Bibliotherapy:

Purchase and seek donations for a library designed for the abused child. The following is a list of books that would be appropriate for such a library:

Don't Hurt Laurie Roberts, 1977. N.Y. Atheneum.

Tough Chauncey D.B. Smith, 1974. N.Y. Crowell.

The Lottery Rose Irene Hunts, 1976. N.Y. Scribners.

The Pinballs Betsy Byars, 1977. N.Y. Harper and Row.

Foster Child M.D. Bauer, 1977. N.Y. Seabury.

Like The Loin's Tooth M. Kellogg, 1972. New York. Farrar, Straus, Giroux.

Also, video tapes, films and other educational material should be collected for use in community child abuse awareness programs and housed in the library of the center.

Anatomical Dolls, Puppets and Art Materials:

Play therapy for children requires special materials such as puppets, small figures of people, art materials for drawing and specially made anatomically correct dolls. These dolls are relatively expensive but very necessary for interviewing young children who have not developed language and communication skills.

Videotaping:

Because of the McMartin Day Care case in Los Angeles, California, videotaping has been put on a temporary hold. Most

District Attorney's are adamant about not using it. They are afraid of creating a product that could get rammed down their throats in the court room. Three things can happen with video tape: it can be used as culpatory evidence, kids can be "beaten over the head" with it (by the defense attorney), and the skills of the interviewer can come under attack.

Unfortunately, a video tape can be a very useful tool in therapy. Kee MacFarlane has shown a video tape of a small child disclosing sexual abuse to the offender and gotten an immediate confession. A video taping of the child's interview can also be useful by showing it to the parent before the parent gets back with the child. This helps the parent collect him/herself from the shock before their child sees him/her (MacFarlane et al., 1986).

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